FOR OHF USE

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0038877

Facility Name: FOX RIVER PAVILION

Address: 400 NEW YORK STREET (Number) AURORA (City) 60505 (Zip Code)

County: KANE

Telephone Number: (630) 897-8714 **Fax #** (630) 897-7123

IDPA ID Number: 36-3890248

Date of Initial License for Current Owners: 06/01/93

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust	X	Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name:: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) See Accountants' Compilation Report Attached (Date)

(Print Name and Title) MARVIN FOX, C.P.A.

(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 236-1111 Fax# (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	121	Skilled (SNF)	121	44,165	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	121	TOTALS	121	44,165	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	15,871	1,749	2,968	20,588	8
9	SNF/PED					9
10	ICF	21,041	579		21,620	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	36,912	2,328	2,968	42,208	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.57%

D. How many bed-hold days during this year were paid by Public Aid?
531 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 06/01/93

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 06/01/93 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 29 and days of care provided 2817

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	157,190	13,168	7,268	177,626		177,626	5,598	183,224			1
2	Food Purchase		196,988		196,988	(19,418)	177,570	(108)	177,462			2
3	Housekeeping	148,514	178	11,847	160,539		160,539		160,539			3
4	Laundry	69,250	17,420		86,670		86,670		86,670			4
5	Heat and Other Utilities			124,009	124,009		124,009	984	124,993			5
6	Maintenance	59,193	71	87,494	146,758		146,758	(7,541)	139,217			6
7	Other (specify):*							1,463	1,463			7
8	**TOTAL General Services**	434,147	227,825	230,618	892,590	(19,418)	873,172	395	873,567			8
	B. Health Care and Programs											
9	Medical Director			22,513	22,513		22,513		22,513			9
10	Nursing and Medical Records	1,504,946	82,356	165,409	1,752,711		1,752,711	3,501	1,756,212			10
10a	Therapy	20,897	4,369	5,895	31,161		31,161	(521)	30,640			10a
11	Activities	60,156	5,228	450	65,834		65,834		65,834			11
12	Social Services	55,655		4,575	60,230		60,230		60,230			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*							3,085	3,085			15
16	**TOTAL Health Care and Programs**	1,641,654	91,953	198,842	1,932,449		1,932,449	6,065	1,938,514			16
	C. General Administration											
17	Administrative	63,261		275,216	338,477		338,477	112,181	450,658			17
18	Directors Fees											18
19	Professional Services			59,070	59,070		59,070	(285,357)	(226,287)			19
20	Dues, Fees, Subscriptions & Promotions			89,427	89,427		89,427	(55,432)	33,995			20
21	Clerical & General Office Expenses	139,437	45,111	156,318	340,866		340,866	(1,372)	339,494			21
22	Employee Benefits & Payroll Taxes			328,879	328,879	19,418	348,297		348,297			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,634	4,634		4,634	309	4,943			24
25	Other Admin. Staff Transportation			3,304	3,304		3,304		3,304			25
26	Insurance-Prop.Liab.Malpractice			85,963	85,963		85,963	14	85,977			26
27	Other (specify):*							31,132	31,132			27
28	**TOTAL General Administration**	202,698	45,111	1,002,811	1,250,620	19,418	1,270,038	(198,525)	1,071,513			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,278,499	364,889	1,432,271	4,075,659		4,075,659	(192,065)	3,883,594			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number FOX RIVER PAVILION #0038877 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			30,343	30,343		30,343	104,149	134,492			30
31	Amortization of Pre-Op. & Org.			1,500	1,500		1,500	40,760	42,260			31
32	Interest			41,125	41,125		41,125	296,122	337,247			32
33	Real Estate Taxes			43,240	43,240		43,240	(105)	43,135			33
34	Rent-Facility & Grounds			422,865	422,865		422,865	(413,390)	9,475			34
35	Rent-Equipment & Vehicles			6,432	6,432		6,432	(110)	6,322			35
36	Other (specify):*							(2,777)	(2,777)			36
37	**TOTAL Ownership**			545,505	545,505		545,505	24,649	570,154			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		145,268	298,081	443,349		443,349	(33,763)	409,586			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			66,247	66,247		66,247		66,247			42
43	Other (specify):*	22,073		218	22,291		22,291	(22,291)	1			43
44	**TOTAL Special Cost Centers**	22,073	145,268	364,546	531,887		531,887	(56,054)	475,834			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,300,572	510,157	2,342,322	5,153,051		5,153,051	(223,469)	4,929,582			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	14,405	30		9
10	Interest and Other Investment Income	(706)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(108)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(25)	21		18
19	Entertainment				19
20	Contributions	(6,550)	21		20
21	Owner or Key-Man Insurance	(6,539)	21		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(78,250)	21		24
25	Fund Raising, Advertising and Promotional	(48,992)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(9,367)	20		28
29	Other-Attach Schedule	(49,869)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (186,002)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(37,468)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (37,468)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (223,469)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

FOX RIVER PAVILION

ID# 0038877

Report Period Beginning: 01/01/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	TRUST FES	$ (250)	21	1
2	CABLE TV	(4,017)	21	2
3	IL COUNCIL LTC - NON-ALLOW	(2,652)	20	3
4	MARKETING SALARY	(22,073)	43	4
5	MARKETING CONSULTANT	(218)	43	5
6	PRIOR YEAR LEGAL BILLS	(9,871)	19	6
7	CAPITALIZED R&M	(7,702)	6	7
8	BANK CHARGES	(1,970)	21	8
9	NON ALLOW MARKETING TRAVEL	(1,012)	35	9
10	R/E TAX LATE FEE	(105)	33	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49				49
50				50
51				51
52				52
53				53
54				54
55				55
56				56
57				57
58				58
59				59
60				60
61				61
62				62
63				63
64				64
65				65
66				66
67				67
68				68
69				69
70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90				90
91				91

STATE OF ILLINOIS

Summary A

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary				1,157			70			4,371		5,598	1
2	Food Purchase	(108)											(108)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			790			194						984	5
6	Maintenance	(7,702)		32			129						(7,541)	6
7	Other (specify):*				1,031			432					1,463	7
8	**TOTAL General Services**	(7,810)		822	2,188		323	502			4,371		395	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			12,303			4,956				(13,758)		3,501	10
10a	Therapy								(274)	(247)			(521)	10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*			2,020			1,065						3,085	15
16	**TOTAL Health Care and Programs**			14,323			6,021		(274)	(247)	(13,758)		6,065	16
	C. General Administration													
17	Administrative			66,253		5,939	39,989						112,181	17
18	Directors Fees													18
19	Professional Services	(9,871)		3,983	(203,740)	(7,795)	3,542	(71,476)					(285,357)	19
20	Fees, Subscriptions & Promotions	(61,011)		3,915		31	1,633						(55,432)	20
21	Clerical & General Office Expenses	(97,601)		55,971		8,705	31,553						(1,372)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			112			197						309	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			13			1						14	26
27	Other (specify):*			16,596		285	14,251						31,132	27
28	**TOTAL General Administration**	(168,483)		146,843	(203,740)	7,165	91,166	(71,476)					(198,525)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(176,293)		161,988	(201,553)	7,165	97,510	(70,974)	(274)	(247)	(9,387)		(192,065)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	14,405	79,581	8,435		1,403	325						104,149	30
31	Amortization of Pre-Op. & Org.		40,760										40,760	31
32	Interest	(706)	293,682	2,074		1,076	(4)						296,122	32
33	Real Estate Taxes	(105)											(105)	33
34	Rent-Facility & Grounds		(422,865)	6,451			3,024						(413,390)	34
35	Rent-Equipment & Vehicles	(1,012)			673		229						(110)	35
36	Other (specify):*					(2,777)							(2,777)	36
37	TOTAL Ownership	12,582	(8,842)	16,960	673	(298)	3,574						24,649	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers								(13,085)	(13,818)	(6,860)		(33,763)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(22,291)											(22,291)	43
44	TOTAL Special Cost Centers	(22,291)							(13,085)	(13,818)	(6,860)		(56,054)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(186,002)	(8,842)	178,948	(200,880)	6,867	101,084	(70,974)	(13,359)	(14,065)	(16,247)		(223,469)	45

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
BRIAN CLOCH	50%	SEE ATTACHED		SEE ATTACHED		
MICHAEL FILIPPO	50%					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT	$ 422,865	FOX RIVER PAVILION PARTNERSHIP		$	$ (422,865)	1
2	V	30	DEPRECIATION		FOX RIVER PAVILION PARTNERSHIP		79,581	79,581	2
3	V	32	INTEREST		FOX RIVER PAVILION PARTNERSHIP		293,682	293,682	3
4	V	31	AMORTIZATION		FOX RIVER PAVILION PARTNERSHIP		40,760	40,760	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 422,865			$ 414,023	$ * (8,842)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	QUALITY CARE MANAGEMENT	100.00%	$ 790	$ 790	15
16	V	6	REPAIRS AND MAINT.		QUALITY CARE MANAGEMENT	100.00%	32	32	16
17	V	10	SAL-NURSING		QUALITY CARE MANAGEMENT	100.00%	11,272	11,272	17
18	V	10	NURS SAL-M. CLARKE		QUALITY CARE MANAGEMENT	100.00%	1,031	1,031	18
19	V	15	EMP. BEN.-H.C.		QUALITY CARE MANAGEMENT	100.00%	2,020	2,020	19
20	V	17	ADMIN SAL-NON-OWNER		QUALITY CARE MANAGEMENT	100.00%	16,158	16,158	20
21	V	17	ADMIN. SAL.- A. SALTZMAN		QUALITY CARE MANAGEMENT	100.00%	2,742	2,742	21
22	V	17	ADMIN. SAL - B BENOUDIZ		QUALITY CARE MANAGEMENT	100.00%	9,032	9,032	22
23	V	17	ADMIN. SAL. - B. CLOCH		QUALITY CARE MANAGEMENT	100.00%	23,761	23,761	23
24	V	17	ADMIN. SAL. - B. TEITELBAUM		QUALITY CARE MANAGEMENT	100.00%	3,453	3,453	24
25	V	17	ADMIN. SAL - J. MEISELS		QUALITY CARE MANAGEMENT	100.00%	1,421	1,421	25
26	V	17	ADMIN. SAL. - STEVE VAN CAMP		QUALITY CARE MANAGEMENT	100.00%			26
27	V	17	ADMIN. SAL. - MIKE FILIPPO		QUALITY CARE MANAGEMENT	100.00%	9,686	9,686	27
28	V	19	PROFESSIONAL FEES		QUALITY CARE MANAGEMENT	100.00%	3,983	3,983	28
29	V	20	FEES,SUBSCRIPTIONS		QUALITY CARE MANAGEMENT	100.00%	3,915	3,915	29
30	V	21	CLERICAL & GENERAL		QUALITY CARE MANAGEMENT	100.00%	50,062	50,062	30
31	V	21	ACCTG SAL-B. LARIMORE		QUALITY CARE MANAGEMENT	100.00%	3,960	3,960	31
32	V	21	OFFICE SAL-M. CLOCH		QUALITY CARE MANAGEMENT	100.00%	1,949	1,949	32
33	V	24	EDUCATION & SEMINAR		QUALITY CARE MANAGEMENT	100.00%	112	112	33
34	V	26	INSURANCE		QUALITY CARE MANAGEMENT	100.00%	13	13	34
35	V	27	EMP. BEN.-GEN. ADMIN.		QUALITY CARE MANAGEMENT	100.00%	16,596	16,596	35
36	V	30	DEPRECIATION		QUALITY CARE MANAGEMENT	100.00%	8,435	8,435	36
37	V	32	INTEREST		QUALITY CARE MANAGEMENT	100.00%	2,074	2,074	37
38	V	34	OFFICE RENT-UNRELATED		QUALITY CARE MANAGEMENT	100.00%	6,451	6,451	38
39	Total			$			$ 178,948	$ * 178,948	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	35	EQUIPMENT RENTAL	$	QUALITY CARE MANAGEMENT	100.00%	$ 673	$ 673	15
16	V								16
17	V	19	CORPORATE ALLOCATION	203,740	QUALITY CARE MANAGEMENT	100.00%		(203,740)	17
18	V								18
19	V	6	REPAIRS AND MAINT.		QUALITY CARE MANAGEMENT	100.00%			19
20	V	7	EMP. BEN.-GEN. SERV.		QUALITY CARE MANAGEMENT	100.00%			20
21	V								21
22	V	1	DIETICIAN SALARIES	5,123	QUALITY CARE MANAGEMENT	100.00%	6,279	1,157	22
23	V	7	EMP. BEN.-GEN. ADMIN.		QUALITY CARE MANAGEMENT	100.00%	1,031	1,031	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 208,863			$ 7,983	$ * (200,880)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMIN SAL-NON-OWNER	$	QUALITY CARE MANAGEMENT	100.00%	$ 803	$ 803	15
16	V	17	ADMIN. SAL. - B. CLOCH		QUALITY CARE MANAGEMENT	100.00%	2,568	2,568	16
17	V	17	ADMIN. SAL. - B. TEITELBAUM		QUALITY CARE MANAGEMENT	100.00%	1,819	1,819	17
18	V	17	ADMIN. SAL - J. MEISELS		QUALITY CARE MANAGEMENT	100.00%	749	749	18
19	V	19	PROFESSIONAL FEES		QUALITY CARE MANAGEMENT	100.00%	205	205	19
20	V	19	MGNT FEES-DIRECT ALLOC		QUALITY CARE MANAGEMENT	100.00%	71,475	71,475	20
21	V	20	FEES,SUBSCRIPTIONS		QUALITY CARE MANAGEMENT	100.00%	31	31	21
22	V	21	CLERICAL & GENERAL		QUALITY CARE MANAGEMENT	100.00%	8,705	8,705	22
23	V	27	EMP. BEN.-GEN. ADMIN.		QUALITY CARE MANAGEMENT	100.00%	285	285	23
24	V	30	DEPRECIATION		QUALITY CARE MANAGEMENT	100.00%	1,403	1,403	24
25	V	32	INTEREST		QUALITY CARE MANAGEMENT	100.00%	1,076	1,076	25
26	V	36	GAIN ON SALE OF ASSETS		QUALITY CARE MANAGEMENT	100.00%	(2,777)	(2,777)	26
27	V								27
28	V	19	CORPORATE ALLOCATION	71,475	QUALITY CARE MANAGEMENT	100.00%		(71,475)	28
29	V	19	COMPUTER SERVICES	8,000	QUALITY CARE MANAGEMENT	100.00%		(8,000)	29
30	V								30
31	V	1	DIETICIAN SALARIES		QUALITY CARE MANAGEMENT	100.00%			31
32	V	7	EMP. BEN.-GEN. ADMIN.		QUALITY CARE MANAGEMENT	100.00%			32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 79,475			$ 86,342	$ * 6,867	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	$ 194	$ 194	15
16	V	6	REPAIRS AND MAINT.		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	129	129	16
17	V	10	NURSING		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	658	658	17
18	V	10	SAL-NURSING-M. CLARKE		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	4,298	4,298	18
19	V	15	EMP. BEN.-H.C.		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	1,065	1,065	19
20	V	17	ADMIN SAL-NON-OWNER		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	9,689	9,689	20
21	V	17	ADMIN. SAL.- F. BENJAMIN		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	7,662	7,662	21
22	V	17	ADMIN. SAL - B BENOUDIZ		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	5,521	5,521	22
23	V	17	ADMIN. SAL. - B. CLOCH		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	6,481	6,481	23
24	V	17	ADMIN. SAL. - C. ROSS		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%			24
25	V	17	ADMIN. SAL - S. VAN CAMP		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	4,765	4,765	25
26	V	17	ADMIN. SAL. - M. FILIPPO		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	5,871	5,871	26
27	V	17	ADMIN. SAL. - J. ELOWE		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%			27
28	V	19	PROFESSIONAL FEES		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	3,542	3,542	28
29	V	20	FEES,SUBSCRIPTIONS		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	1,633	1,633	29
30	V	21	CLERICAL & GENERAL		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	29,721	29,721	30
31	V	21	SALARIES-ACCTG-B. LARIMORE		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	1,832	1,832	31
32	V	24	EDUCATION & SEMINAR		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	197	197	32
33	V	26	INSURANCE		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	1	1	33
34	V	27	EMP. BEN.-GEN. ADMIN.		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	14,251	14,251	34
35	V	30	DEPRECIATION		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	325	325	35
36	V	32	INTEREST		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	(4)	(4)	36
37	V	34	OFFICE RENT-UNRELATED		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	3,024	3,024	37
38	V	35	EQUIPMENT RENTAL		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	229	229	38
39	Total			$			$ 101,084	$ * 101,084	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	CORP ALLOC/MGMT FEE	71,476	BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	$	$ (71,476)	15
16	V								16
17	V	6	REPAIRS AND MAINT.		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%			17
18	V	7	EMP. BEN.-GEN. SERV.		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%			18
19	V								19
20	V	1	DIETICIAN SALARIES	1,875	BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	1,945	70	20
21	V	7	EMP. BEN.-GEN. ADMIN.		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	432	432	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 73,351			$ 2,377	$ * (70,974)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10A	REHAB CONSULTING	$ 4,095	AT&R II, LLC	100.00%	$ 3,821	$ (274)	15
16	V	39	ANCILLARY REHAB	195,880	AT&R II, LLC	100.00%	182,795	(13,085)	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 199,975			$ 186,616	$ * (13,359)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10A	REHAB CONSULTING	$ 1,800	Advanced Therapy and Rehab, LLC	100.00%	$ 1,553	$ (247)	15
16	V	39	ANCILLARY REHAB	100,641	Advanced Therapy and Rehab, LLC	100.00%	86,823	(13,818)	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 102,441			$ 88,376	$ * (14,065)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	MEDICAL/TUBE FEED-MDCR	$ 11,424	QUALITY CARE MEDICAL SUPPLY	100.00%	$ 4,564	$ (6,860)	15
16	V	10	MEDICAL SUPPLIES	15,631	QUALITY CARE MEDICAL SUPPLY	100.00%	1,873	(13,758)	16
17	V	1	FOOD SUPPLEMENTS		QUALITY CARE MEDICAL SUPPLY	100.00%	4,371	4,371	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 27,055			$ 10,808	$ * (16,247)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	BRIAN CLOCH	DIR OF OPER	MANAGEMENT	50.00%	SEE ATTACHED	5.97	9.18%	SALARY	$ 32,810	17-7	1
2	MICHAEL FILIPPO	ADMINISTRATIVE	ADMIN	50.00%	SEE ATTACHED	4.65	10.33%	SALARY	15,557	17-7	2
3	MARILYN CLOCH	RELATIVE	CLERICAL	NONE	SEE ATTACHED	2.7	6.75%	SALARY	1,949	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 50,316		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: QUALITY CARE MANAGEMENT
Street Address: 8950 GROSS POINT RD. #E
City / State / Zip Code: SKOKIE, IL. 60077
Phone Number: (847) 663-1155
Fax Number: (847) 663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	258,551	8	$ 7,246	$	28,186	$ 790	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	258,551	8	290		28,186	32	2
3	10	SAL-NURSING	PATIENT DAYS	258,551	8	103,396	103,396	28,186	11,272	3
4	10	NURS SAL-M. CLARKE	PATIENT DAYS	258,551	8	9,458	9,458	28,186	1,031	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	258,551	8	18,527		28,186	2,020	5
6	17	ADMIN SAL-NON-OWNER	PATIENT DAYS	258,551	8	148,217	148,217	28,186	16,158	6
7	17	ADMIN. SAL.- A. SALTZMAN	DIRECT/PATIENT DAYS		6	22,590	22,590		2,742	7
8	17	ADMIN. SAL - B BENOUDIZ	PATIENT DAYS	258,551	8	82,852	82,852	28,186	9,032	8
9	17	ADMIN. SAL. - B. CLOCH	PATIENT DAYS	258,551	8	217,962	217,962	28,186	23,761	9
10	17	ADMIN. SAL. - B. TEITELBAUM	DIRECT/PATIENT DAYS		5	22,566	22,566		3,453	10
11	17	ADMIN. SAL - J. MEISELS	DIRECT/PATIENT DAYS		5	9,284	9,284		1,421	11
12	17	ADMIN. SAL. - STEVE VAN CA	DIRECT/PATIENT DAYS		3	10,508	10,508			12
13	17	ADMIN. SAL. - MIKE FILIPPO	PATIENT DAYS	258,551	8	88,849	88,849	28,186	9,686	13
14	19	PROFESSIONAL FEES	PATIENT DAYS	258,551	8	36,541		28,186	3,983	14
15	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	258,551	8	35,917		28,186	3,915	15
16	21	CLERICAL & GENERAL	PATIENT DAYS	258,551	8	459,219	364,702	28,186	50,062	16
17	21	ACCTG SAL-B. LARIMORE	DIRECT/PATIENT DAYS		7	35,710	35,710		3,960	17
18	21	OFFICE SAL-M. CLOCH	PATIENT DAYS	258,551	8	17,876	17,876	28,186	1,949	18
19	24	EDUCATION & SEMINAR	PATIENT DAYS	258,551	8	1,028		28,186	112	19
20	26	INSURANCE	PATIENT DAYS	258,551	8	121		28,186	13	20
21	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	258,551	8	152,231		28,186	16,596	21
22	30	DEPRECIATION	PATIENT DAYS	258,551	8	77,371		28,186	8,435	22
23	32	INTEREST	PATIENT DAYS	258,551	8	19,022		28,186	2,074	23
24	34	OFFICE RENT-UNRELATED	PATIENT DAYS	258,551	8	59,175		28,186	6,451	24
25	TOTALS					$ 1,635,956	$ 1,133,970		$ 178,948	25

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: QUALITY CARE MANAGEMENT
Street Address: 8950 GROSS POINT RD. #E
City / State / Zip Code: SKOKIE, IL. 60077
Phone Number: (847) 663-1155
Fax Number: (847) 663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	35	EQUIPMENT RENTAL	PATIENT DAYS	258,551	8	$ 6,176	$	28,186	$ 673	1
2										2
3										3
4										4
5	6	REPAIRS AND MAINT.	PAINTING REVENUE	24,700	4	27,506	27,506			5
6	7	EMP. BEN.-GEN. SERV.	PAINTING REVENUE	24,700	4	4,515				6
7										7
8	1	DIETICIAN SALARIES	DIETICIAN REVENUE	34,652	8	42,478	42,478	5,123	6,279	8
9	7	EMP. BEN.-GEN. ADMIN.	DIETICIAN REVENUE	34,652	8	6,973		5,123	1,031	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 87,648	$ 69,984		$ 7,983	25

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: QUALITY CARE MANAGEMENT
Street Address: 8950 GROSS POINT RD. #E
City / State / Zip Code: SKOKIE, IL. 60077
Phone Number: (847) 663-1155
Fax Number: (847) 663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMIN SAL-NON-OWNER	PATIENT DAYS	89,917	5	$ 5,150	$ 5,150	14,022	$ 803	1
2	17	ADMIN. SAL. - B. CLOCH	PATIENT DAYS	89,917	5	16,467	16,467	14,022	2,568	2
3	17	ADMIN. SAL. - B. TEITELBAUM	PATIENT DAYS	89,917	5	11,667	11,667	14,022	1,819	3
4	17	ADMIN. SAL - J. MEISELS	PATIENT DAYS	89,917	5	4,800	4,800	14,022	749	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	89,917	5	1,316		14,022	205	5
6	19	MGNT FEES-DIRECT ALLOC	DIRECT ALLOCATION		5	541,973			71,475	6
7	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	89,917	5	200		14,022	31	7
8	21	CLERICAL & GENERAL	PATIENT DAYS	89,917	5	55,820		14,022	8,705	8
9	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	89,917	5	1,825		14,022	285	9
10	30	DEPRECIATION	PATIENT DAYS	89,917	5	8,999		14,022	1,403	10
11	32	INTEREST	PATIENT DAYS	89,917	5	6,900		14,022	1,076	11
12	36	GAIN ON SALE OF ASSETS	PATIENT DAYS	89,917	5	(17,809)		14,022	(2,777)	12
13										13
14										14
15										15
16										16
17	1	DIETICIAN SALARIES	DIETICIAN REVENUE	4,053	3	3,527	3,527			17
18	7	EMP. BEN.-GEN. ADMIN.	DIETICIAN REVENUE	4,053	3	71				18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 640,906	$ 41,611		$ 86,342	25

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: BOULEVARD HEALTHCARE MANAGEMEN
Street Address: 8950 GROSS POINT RD. SUITE 600
City / State / Zip Code: SKOKIE, IL. 60077
Phone Number: (847) 663-1155
Fax Number: (847) 663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	147,139	8	$ 2,034	$	14,022	$ 194	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	147,139	8	1,354		14,022	129	2
3	10	NURSING	PATIENT DAYS	147,139	8	6,902	5,142	14,022	658	3
4	10	SAL-NURSING-M. CLARKE	PATIENT DAYS	147,139	8	45,100	45,100	14,022	4,298	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	147,139	8	11,172		14,022	1,065	5
6	17	ADMIN SAL-NON-OWNER	PATIENT DAYS	147,139	8	101,666	101,666	14,022	9,689	6
7	17	ADMIN. SAL.- F. BENJAMIN	PATIENT DAYS	147,139	8	80,400	80,400	14,022	7,662	7
8	17	ADMIN. SAL - B BENOUDIZ	PATIENT DAYS	147,139	8	57,937	57,937	14,022	5,521	8
9	17	ADMIN. SAL. - B. CLOCH	PATIENT DAYS	147,139	8	68,004	68,004	14,022	6,481	9
10	17	ADMIN. SAL. - C. ROSS	DIRECT/PATIENT DAYS		4	4,050	4,050	14,022		10
11	17	ADMIN. SAL - S. VAN CAMP	PATIENT DAYS	147,139	8	50,000	50,000	14,022	4,765	11
12	17	ADMIN. SAL. - M. FILIPPO	PATIENT DAYS	147,139	8	61,604	61,604	14,022	5,871	12
13	17	ADMIN. SAL. - J. ELOWE	AVERAGE HOURS	10	3	12,210	12,210	3		13
14	19	PROFESSIONAL FEES	PATIENT DAYS	147,139	8	37,170		14,022	3,542	14
15	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	147,139	8	17,139		14,022	1,633	15
16	21	CLERICAL & GENERAL	PATIENT DAYS	147,139	8	311,878	242,119	14,022	29,721	16
17	21	SALARIES-ACCTG-B. LARIMO	DIRECT/PATIENT DAYS		7	17,000	17,000	14,022	1,832	17
18	24	EDUCATION & SEMINAR	PATIENT DAYS	147,139	8	2,070		14,022	197	18
19	26	INSURANCE	PATIENT DAYS	147,139	8	13		14,022	1	19
20	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	147,139	8	149,543		14,022	14,251	20
21	30	DEPRECIATION	PATIENT DAYS	147,139	8	3,414		14,022	325	21
22	32	INTEREST	PATIENT DAYS	147,139	8	(39)		14,022	(4)	22
23	34	OFFICE RENT-UNRELATED	PATIENT DAYS	147,139	8	31,727		14,022	3,024	23
24	35	EQUIPMENT RENTAL	PATIENT DAYS	147,139	8	2,402		14,022	229	24
25	TOTALS					$ 1,074,750	$ 745,232		$ 101,084	25

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: BOULEVARD HEALTHCARE MANAGEMEN
Street Address: 8950 GROSS POINT RD. SUITE 600
City / State / Zip Code: SKOKIE, IL. 60077
Phone Number: (847) 663-1155
Fax Number: (847) 663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3	6	REPAIRS AND MAINT.	PAINTING REVENUE	8,632	2	7,120	7,120			3
4	7	EMP. BEN.-GEN. SERV.	PAINTING REVENUE	8,632	2	1,583				4
5						$	$			5
6	1	DIETICIAN SALARIES	DIETICIAN REVENUE	19,790	8	20,524	20,524	1,875	1,945	6
7	7	EMP. BEN.-GEN. ADMIN.	DIETICIAN REVENUE	19,790	8	4,564		1,875	432	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 33,791	$ 27,644		$ 2,377	25

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: AT&R II, LLC
Street Address: 8950 GROSS POINT RD. #E
City / State / Zip Code: SKOKIE, IL 60077
Phone Number: (847)663-1155
Fax Number: (847)663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10A	REHAB CONSULTING	DIRECT ALLOCATION						3,821	1
2	39	ANCILLARY REHAB	DIRECT ALLOCATION						182,795	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 186,616	25

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: ADVANCED THERAPY AND REHAB, LLC
Street Address: 8950 GROSS POINT RD. #E
City / State / Zip Code: SKOKIE, IL 60077
Phone Number: (847)663-1155
Fax Number: (847)663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10A	REHAB CONSULTING	DIRECT ALLOCATION						1,553	1
2	39	ANCILLARY REHAB	DIRECT ALLOCATION						86,823	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 88,376	25

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: QUALITY CARE MEDICAL SUPPLY
Street Address: 8950 GROSS POINT RD. #E
City / State / Zip Code: SKOKIE, IL 60077
Phone Number: (847)663-1155
Fax Number: (847)663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	MEDICAL/TUBE FEED-MDCR	DIRECT ALLOCATION						4,564	1
2	10	MEDICAL SUPPLIES	DIRECT ALLOCATION						1,873	2
3	1	FOOD SUPPLEMENTS	DIRECT ALLOCATION						4,371	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 10,808	25

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	MANUFACTURER'S BANK		X	MORTGAGE	$37,104	6/15/00	$ 4,200,000	$ 4,026,403	7/1/02	9.50%	$ 293,682	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MANUFACTURER'S BANK		X	LINE OF CREDIT	N/A	6.15.00	900,000	679,000	DEMAND	4.75%	37,897	6
7												7
8												8
9	TOTAL Facility Related				$37,104		$ 5,100,000	$ 4,705,403			$ 331,579	9
	B. Non-Facility Related*											
10	See Supplemental Schedule										5,668	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 5,668	14
15	TOTALS (line 9+line14)						$ 5,100,000	$ 4,705,403			$ 337,247	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	INTEREST INCOME						$	$			$ (706)	1
2	AIC CREDIT										2,914	2
3	KANE COUNTY COLLECTOR										315	3
4	ALLOC QUALITY CARE MGMT										2,074	4
5	ALLOC QUALITY CARE MGMT										1,076	5
6	ALLOC BOULEVARD HC MGMT										(4)	6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ 5,668	21

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2000 report.	$	42,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	42,040	2
3. Under or (over) accrual (line 2 minus line 1).	$	40	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	43,200	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	43,240	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	44,205	8
	1997	39,207	9
	1998	39,811	10
	1999	40,538	11
	2000	42,040	12

REAL ESTATE TAX ACCRUAL = 42,040 X 1.03 Rounded to 43,200

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME FOX RIVER PAVILION COUNTY KANE

FACILITY IDPH LICENSE NUMBER 0038877

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	15-22-451-001	Long Term Care Property	$ 37,824.32	$ 37,824.32
2.	15-22-451-002	Long Term Care Property	$ 1,433.82	$ 1,433.82
3.	15-22-451-003	Long Term Care Property	$ 1,433.82	$ 1,433.82
4.	15-22-451-004	Long Term Care Property	$ 1,242.56	$ 1,242.56
5.	15-24-377-010	Long Term Care Property	$ 105.42	$ 105.42
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 42,039.94	$ 42,039.94

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 31,808 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 3,000
2. Number of Years Over Which it is Being Amortized: LOAN - 12M
3. Current Period Amortization: 42,260
4. Dates Incurred: 2000

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1993	35,735		20	1,788	1,788	13,970	9
10	Various			1994	37,645		20	1,491	1,491	11,310	10
11	Various			1995	110,619		20	5,747	5,747	36,814	11
12	Various			1996	61,835		20	3,093	(3,093)	17,224	12
13	Various			1997	51,869		20	2,595	2,595	11,446	13
14								-		-	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		3,103,650	79,581		79,581		122,687	68
69	Financial Statement Depreciation			9,341			(9,341)		69
70	TOTAL (lines 4 thru 69)		$ 3,401,353	$ 88,922		$ 94,295	$ (813)	$ 213,451	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,401,353	$ 88,922		$ 94,295	$ 5,373	$ 213,451	1
2	DOOR ALARMS	1998	1,946		20	97	97	380	2
3	EMERG PWR OUTLETS	1998	15,530		20	777	777	3,043	3
4	FIRE DAMPERS	1998	3,408		20	170	170	652	4
5	DOOR	1998	1,490		20	75	75	288	5
6	SEWER PIPE	1998	950		20	48	48	188	6
7	HOT WTR HTR	1998	8,900		20	445	445	1,520	7
8	FIRE DAMPERS	1998	17,500		20	875	875	2,990	8
9	RACHELS PLACE IMPROV	1998	5,229		20	261	261	805	9
10	ACCESS DOORS	1998	1,257		20	63	63	215	10
11	GENERATOR REPAIR	1998	12,791		20	640	640	2,133	11
12	TANK	1998	8,335		20	417	417	1,321	12
13	DOORS	1998	1,551		20	78	78	247	13
14	ELECTRICAL WORK	1998	2,000		20	100	100	308	14
15	EXIT SIGNS	1998	1,933		20	97	97	299	15
16	FIRE WALLS	1998	1,500		20	75	75	231	16
17	ELEC PARTS	1998	3,251		20	163	163	503	17
18	ELEV OP PANEL	1999	2,690		20	135	135	394	18
19	PUMP/BOILER REPAIR	1999	2,316		20	116	116	338	19
20	ROOF FANS	1999	2,900		20	145	145	363	20
21	DOOR	1999	1,696		20	85	85	213	21
22	ELEV OP PANEL	1999	2,690		20	135	135	326	22
23	TUCKPOINTING	1999	1,075		20	54	54	126	23
24	TANK REMOVAL	1999	2,670		20	134	134	369	24
25	CORDED STATION	1999	594		20	30	30	73	25
26	LIGHTING SUPPLIES	1999	1,198		20	60	60	155	26
27	VARIOUS REPAIRS	1999	683		20	34	34	88	27
28	VARIOUS REPAIRS	1999	1,938		20	97	97	226	28
29	FIXTURES	1999	603		20	30	30	92	29
30	DOORS	2000	1,948		20	50	50	90	30
31	CARPETING	2000	1,407		20	36	36	62	31
32	CHILLER COMPRESSOR	2000	19,800		20	508	508	783	32
33	PUMP REPAIR	2000	1,978		20	51	51	66	33
34	TOTAL (lines 1 thru 33)		$ 3,535,110	$ 88,922		$ 100,376	$ 11,454	$ 232,338	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,535,110	$ 88,922		$ 100,376	$ 11,454	$ 232,338	1
2	BOILER PUMP	2000	1,166		20	58	58	111	2
3	WALL COVERINGS	2000	722		20	36	36	66	3
4	BLINDS	2000	1,121		20	56	56	107	4
5	FIRE SPRINKLER	2000	576		20	29	29	55	5
6	PAINTING & DECOR	2000	2,834		20	142	142	213	6
7	REPLC & WELD HTG FLG	2001	1,019		20	8	8	8	7
8	DOOR INSTALLATION	2001	2,840		20	9	9	9	8
9	CARPET INSTALLATION	2001	1,079		20	1	1	1	9
10	DOOR	2001	663		20	30	30	30	10
11	WATER PUMP	2001	1,738		20	72	72	72	11
12	ELECTRIC WORK	2001	1,895		20	39	39	39	12
13	LOCKS	2001	811		20	3	3	3	13
14	ELECTRIC WORK	2001	2,595		20	11	11	11	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,554,169	$ 88,922		$ 100,870	$ 11,948	$ 233,063	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 3,554,169	$ 88,922		$ 100,870	$ 11,948	$ 233,063	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,554,169	$ 88,922		$ 100,870	$ 11,948	$ 233,063	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 3,554,169	$ 88,922		$ 100,870	$ 11,948	$ 233,063	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,554,169	$ 88,922		$ 100,870	$ 11,948	$ 233,063	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 3,554,169	$ 88,922		$ 100,870	$ 11,948	$ 233,063	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,554,169	$ 88,922		$ 100,870	$ 11,948	$ 233,063	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 3,554,169	$ 88,922		$ 100,870	$ 11,948	$ 233,063	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,554,169	$ 88,922		$ 100,870	$ 11,948	$ 233,063	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 3,554,169	$ 88,922		$ 100,870	$ 11,948	$ 233,063	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,554,169	$ 88,922		$ 100,870	$ 11,948	$ 233,063	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 3,554,169	$ 88,922		$ 100,870	$ 11,948	$ 233,063	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,554,169	$ 88,922		$ 100,870	$ 11,948	$ 233,063	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			2000		$ 3,103,650	$ 79,581	35	$ 79,581	$	$ 122,687	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,103,650	$ 79,581		$ 79,581	$	$ 122,687	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 246,203	$ 30,840	$ 30,321	$ (519)	10	$ 103,531	71
72	Current Year Purchases	26,271	325	3,301	2,976	10	3,301	72
73	Fully Depreciated Assets	15,310				10	15,310	73
74								74
75	TOTALS	$ 287,784	$ 31,165	$ 33,622	$ 2,457		$ 122,142	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,841,953	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 120,087	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 134,492	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 14,405	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 355,205	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/01 Ending: 12/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions		QUALITY CARE MGMT		6,451			4
5			BOULEVARD HC MGMT		3,024			5
6								6
7	TOTAL				$ 9,475 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 7,335 Description: SEE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 3,345	$		$ 3,345	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			5,451			5,451	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			288,555			288,555	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 03	# of prescrpts			730	55,379		56,109	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):						89,889		89,889	13
14	TOTAL			$		$ 298,081	$ 145,268		$ 443,349	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/01 Ending: 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (63,120)	$ (63,120)	1
2	Cash-Patient Deposits	35,479	35,479	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,083,035	1,083,035	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	34,632	34,632	6
7	Other Prepaid Expenses	3,075	3,075	7
8	Accounts Receivable (owners or related parties)	199,989	895,530	8
9	Other(specify): See supplemental schedule	60,175	60,175	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,353,265	$ 2,048,806	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		344,850	13
14	Buildings, at Historical Cost		3,103,650	14
15	Leasehold Improvements, at Historical Cost	363,494	363,494	15
16	Equipment, at Historical Cost	248,691	248,691	16
17	Accumulated Depreciation (book methods)	(270,385)	(393,072)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		81,519	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(62,838)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule	9,328	9,328	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 351,128	$ 3,695,622	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,704,393	$ 5,744,428	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,186,193	$ 1,186,193	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	35,479	35,479	28
29	Short-Term Notes Payable	679,000	679,000	29
30	Accrued Salaries Payable	94,436	94,436	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,265	9,265	31
32	Accrued Real Estate Taxes(Sch.IX-B)	43,200	43,200	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See supplemental schedule			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,047,573	$ 2,047,573	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,026,403	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 4,026,403	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,047,573	$ 6,073,976	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (343,180)	$ (329,548)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,704,393	$ 5,744,428	48

*(See instructions.)

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (398,519)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (398,519)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	83,214	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(27,875)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 55,339	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (343,180)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,134,150	1
2	Discounts and Allowances for all Levels	(678,722)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,455,428	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	569,269	6
7	Oxygen	34,659	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 603,928	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	94,153	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,836	19
20	Radiology and X-Ray	24,625	20
21	Other Medical Services	51,977	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 174,591	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	706	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 706	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	1,612	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,612	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,236,265	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	892,590	31
32	Health Care	1,932,449	32
33	General Administration	1,250,620	33
	B. Capital Expense		
34	Ownership	545,505	34
	C. Ancillary Expense		
35	Special Cost Centers	465,640	35
36	Provider Participation Fee	66,247	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,153,051	40
41	**Income before Income Taxes (line 30 minus line 40)****	83,214	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 83,214	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? CASH BASIS If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,518	1,734	$ 47,608	$ 27.46	1
2	Assistant Director of Nursing	1,979	2,125	50,649	23.84	2
3	Registered Nurses	26,538	29,248	726,935	24.85	3
4	Licensed Practical Nurses	3,626	3,779	81,662	21.61	4
5	Nurse Aides & Orderlies	44,505	46,258	569,932	12.32	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,605	1,669	20,897	12.52	8
9	Activity Director	1,988	2,293	25,558	11.15	9
10	Activity Assistants	5,609	6,190	34,598	5.59	10
11	Social Service Workers	5,442	5,602	55,655	9.93	11
12	Dietician					12
13	Food Service Supervisor	2,029	2,246	41,598	18.52	13
14	Head Cook					14
15	Cook Helpers/Assistants	17,026	17,988	115,592	6.43	15
16	Dishwashers					16
17	Maintenance Workers	4,010	4,363	59,193	13.57	17
18	Housekeepers	18,595	19,897	148,514	7.46	18
19	Laundry	9,033	9,526	69,250	7.27	19
20	Administrator	1,973	2,226	63,261	28.42	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,550	9,114	139,437	15.30	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,567	2,567	28,160	10.97	31
32	Other Health Care(specify)					32
33	Other(specify)	702	702	22,073	31.43	33
34	TOTAL (lines 1 - 33)	157,294	167,526	$ 2,300,572 *	$ 13.73	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	242	$ 7,268	01-03	35
36	Medical Director	235	22,513	09-03	36
37	Medical Records Consultant	44	1,760	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	121	4,202	10-03	39
40	Physical Therapy Consultant	52	2,329	10a-03	40
41	Occupational Therapy Consultant	79	3,566	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	9	450	11-03	44
45	Social Service Consultant	92	4,575	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	873	$ 46,663		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	797	$ 38,208	10-03	50
51	Licensed Practical Nurses	1,561	59,625	10-03	51
52	Nurse Aides	2,492	61,614	10-03	52
53	TOTAL (lines 50 - 52)	4,850	$ 159,447		53

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
KEN BOGARD	ADMINISRTATOR		$ 63,261
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 63,261

B. Administrative - Other

Description	Amount
QUALITY CARE MANAGEMENT	$ 275,216
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 275,216

C. Professional Services

Vendor/Payee	Type	Amount
WINSTON & STRAWN	LEGAL	$ 9,755
WALINSKI & TRUNKETT	LEGAL	156
SACHNOFF & WEAVER	LEGAL	14,988
FR&R	ACCOUNTING	15,659
HEALTH DATA SYSTMS	COMPUTER CONSULTANT	4,181
ACCU-MED	COMPUTER CONSULTANT	137
HORIZON HEALTHCARE	COMPUTER CONSULTANT	2,205
RMS BUSINESS SYSTEMS	COMPUTER CONSULTANT	3,273
QUALITY CARE MGMT	COMPUTER CONSULTANT	8,000
PERSONNEL PLANNERS	UNEMPLOYMENT CNSLT	506
DOCUMENTATION SOLUTIONS	CONSULTANT	210
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 59,070

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 35,517
Unemployment Compensation Insurance	21,541
FICA Taxes	175,994
Employee Health Insurance	79,441
Employee Meals	19,418
Illinois Municipal Retirement Fund (IMRF)*	
401K EXPENSE	10,033
EMPLOYEE BENEFITS	6,353
TOTAL (agree to Schedule V, line 22, col.8)	$ 348,296

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	22,019
Health Care Worker Background Check	1,000
(Indicate # of checks performed 83)	
YELLOW PAGE ADVERTISING	9,367
PROMOTIONAL ADVERTISING	48,992
DUES & SUSCRIPTIONS	920
IL COUNCIL LTC	6,377
LICENSES & FEES	752
SEE SCHEDULE	2,927
Less: Public Relations Expense	
Non-allowable advertising	(48,992)
Yellow page advertising	(9,367)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 33,995

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	4,634
ALLOC QUALITY CARE MGMT	112
BOULEVARD HC MGMT	197
Entertainment Expense	
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,943

**See instructions.

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number FOX RIVER PAVILION # 0038877 Report Period Beginning: 01/01/01 Ending: 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL LTC = $6,377**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **NONE** Line **N/A**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **66,247**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **19,418** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees